

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07900

7902

Reg. Dist. No.

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Charles</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Charles</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pisgah</u>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pisgah</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS <u>1</u>	
3. NAME OF DECEASED (Type or print) <u>HAMILTON</u> First <u>A</u> Middle <u>BOWIE</u> Last			4. DATE OF DEATH Month <u>7</u> Day <u>5</u> Year <u>1958</u>		
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec 31 1889</u>		9. AGE (In years last birthday) <u>68</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Auto Mechanic</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Gov.</u>		11. BIRTHPLACE (State or foreign country) <u>Pisgah Md</u>	
13. FATHER'S NAME <u>Hamilton A Bowie</u>			14. MOTHER'S MAIDEN NAME <u>Bertha Wilber</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>213-18-1143</u>		17. INFORMANT <u>Harry C Bowie Port Tobacco Md</u> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction</u> 420.1 DUE TO (b) <u>Hypertensive Arteriosclerotic Heart Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH <u>15 min.</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>none</u>					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>no injury</u>			
20c. TIME OF INJURY Month, Day, Year <u>7-5-1958</u> Hour <u>11:45</u> a. m. <input checked="" type="checkbox"/> p. m. <input type="checkbox"/>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>PISGAH, CHARLES, MD.</u>	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <u>V B Dettor</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>7-5-58</u>	
EXAMINER'S NAME (Type) <u>V. B. DETTOR</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>		22b. DATE THEREOF <u>July 8, 1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Methodist Church</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Richard Inc Rayphala</u>		ADDRESS <u>Pisgah</u>		24a. REC'D BY REGISTRAR <u>W. H. Search</u> 24b. REGISTRAR'S SIGNATURE <u>W. H. Search</u>	
DATE <u>JUL 10 '58</u>					

7903

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <i>Charles</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Charles</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>La Plata</i>		c. LENGTH OF STAY IN 1b <i>X</i> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Ripley</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>D.O.A. Physicians Mem. Hospital</i>		d. STREET ADDRESS <i>-</i>	
3. NAME OF DECEASED (Type or print) <i>GUY</i> First <i>Q</i> Middle <i>BUTT</i> Last		4. DATE OF DEATH Month <i>JULY</i> Day <i>14</i> Year <i>1958</i>	
5. SEX <i>MALE</i>	6. COLOR OR RACE <i>WHITE</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>JULY 2, 1910</i>
9. AGE (in years last birthday) <i>48</i> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) <i>U.S.A.</i>		12. CITIZEN OF WHAT COUNTRY <i>U.S.A.</i>	
13. FATHER'S NAME <i>Harry S. Butt</i>		14. MOTHER'S MAIDEN NAME <i>Leverne Baker</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>577-140898</i>	
17. INFORMANT <i>Mrs. Edna Butt</i> Address <i>Ripley, Md.</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute Posterior Myocardial Infarction</i> 420.1 DUE TO (b) <i>Arteriosclerotic Coronary Artery Disease</i> EST. 10 yrs. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) <i></i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Previous myocardial infarction</i>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>No injury</i>	
20c. TIME OF INJURY Month, Day, Year <i>7-14-58</i> Hour <i>9:40</i> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>LA PLATA CHARLES, MD.</i>		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>V.B. Detton</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <i>V.B. DETTON, M.D.</i>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. NAME OF CEMETERY OR CREMATORY <i>Potomac Church</i>		22b. LOCATION (City, town, or county) (State) <i>Potomac Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Archant F.H. Inc.</i>		24a. REC'D BY REGISTRAR <i>7/14/58</i>	
		24b. REGISTRAR'S SIGNATURE <i>Archant</i>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any case, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD.
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. NAME OF DECEASED <u>JOHN J. SMITH</u>		2. SEX <u>Male</u>	
3. AGE <u>45</u>		4. RACE <u>White</u>	
5. DATE OF DEATH <u>July 15, 1945</u>		6. TIME OF DEATH <u>10:30 AM</u>	
7. PLACE OF DEATH <u>Home</u>		8. STREET <u>1234 Main St.</u>	
9. CITY <u>Baltimore</u>		10. COUNTY <u>Harford</u>	
11. STATE <u>Md.</u>		12. ZIP CODE <u>21040</u>	
13. OCCUPATION <u>Engineer</u>			
14. MARITAL STATUS <u>Married</u>			
15. CAUSE OF DEATH <u>Heart Disease</u>			
16. MANNER OF DEATH <u>Natural</u>			
17. SIGNATURE OF EXAMINER <u>[Signature]</u>			
18. TITLE OF EXAMINER <u>Medical Examiner</u>			
19. SIGNATURE OF WITNESS <u>[Signature]</u>			
20. TITLE OF WITNESS <u>Physician</u>			

THIS CERTIFICATE IS TO BE FILED IN THE OFFICE OF THE MEDICAL EXAMINER, BALTIMORE, MARYLAND, AND A COPY IS TO BE FURNISHED TO THE COUNTY CLERK OF THE COUNTY IN WHICH THE DEATH OCCURRED.

1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07902

7904

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 2 Film 0232 7/30/58

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Charles</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Penn. Md.</u> b. COUNTY <u>Charles</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Marbury</u>	c. LENGTH OF STAY IN 1b <u>5 days</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Philadelphia Marbury</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>U.S. Naval Home</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Michael</u> Middle <u>Clancy</u> Last <u>Clancy</u>		4. DATE OF DEATH Month <u>July</u> Day <u>22</u> Year <u>1958</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 25, 1872</u>
9. AGE (In year last birthday) <u>86</u> yrs.		10. IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Sergeant</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Ordnance</u>	
11. BIRTHPLACE (State or foreign country) <u>Ireland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>UNKNOWN</u>		14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u>		16. SOCIAL SECURITY NO. <u>1898-1927</u>	
17. INFORMANT <u>Robert A. Golden</u>		Address <u>Marbury, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary Occlusion</u> Conditions, if any, which gave rise to immediate cause (b) <u>Hypertensive Heart Disease</u> (c) <u>Due to</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Acute Respiratory Infection - 1 day duration</u>		INTERVAL BETWEEN ONSET AND DEATH <u>5 Minutes</u> <u>Several years.</u>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>0</u> a. m. <u>19</u> p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank G. Susan</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Frank A. Susan M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>5/25/58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Moriah Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Philadelphia, Pa.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Archart Funeral Home Inc. La Plata, Md.</u>		24a. REG'D BY REGISTRAR <u>JUL 25 '58</u>	
		24b. REGISTRAR'S SIGNATURE <u>Archart</u>	

MEDICAL CERTIFICATION

2

FOR STATE
USE (IN DEPT)



MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 12
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

[Faint, mostly illegible text and markings on the form, including what appears to be a signature and various checkboxes.]

AC PARTIAL DIVISION

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07903

7905

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Charles</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Penn.</u> b. COUNTY <u>✓</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Mason Springs</u>		c. LENGTH OF STAY IN 1b <u>8 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Philadelphia</u> <u>75X-3</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)			d. STREET ADDRESS <u>2414 E. Sergeant St. 25</u>		
3. NAME OF DECEASED (Type or print) First <u>Samuel</u> Middle <u>Herbert</u> Last <u>Dougherty</u>			4. DATE OF DEATH Month <u>July</u> Day <u>23</u> Year <u>1958</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-8-96</u>	9. AGE (In years last birthday) <u>62</u> yrs.	10. UNDER 1 YEAR <input type="checkbox"/> IF UNDER 24 HRS. <input type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Foreman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Painting</u>		11. BIRTHPLACE (State or foreign country) <u>Philadelphia</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>			13. FATHER'S NAME <u>Samuel Dougherty</u>		
14. MOTHER'S MAIDEN NAME <u>Mary McLaughlin</u>			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> <u>1917-18</u>		
16. SOCIAL SECURITY NO.			17. INFORMANT <u>Mrs. Samuel H. Dougherty</u> Address <u>2414 E. Sergeant St. Phila 25, Pa.</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Unlabeled Heart Disease</u>					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <u>Frank A. Sason</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>7-23-58</u>	
EXAMINER'S NAME (Type) <u>Frank A. Sason M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVAL</u>	22b. DATE THEREOF <u>7-24-58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>NATIONAL CEM.</u>	22d. LOCATION (City, town, or county) (State) <u>BEVERLY, N.J.</u>		
23. FUNERAL DIRECTOR'S SIGNATURE <u>Hunt Funeral Home</u>		ADDRESS <u>WALDORE, M.D.</u>		24a. REC'D BY REGISTRAR DATE <u>JUL 28 '58</u>	24b. REGISTRAR'S SIGNATURE <u>W. H. Leach</u>

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing it and "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, at its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07904

7906

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY CHARLES MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY CHARLES	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LA PLATA		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WALDORF (RURAL)	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION PHYSICIANS MEMORIAL HOSP.		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First GEORGE Middle A. Last GOLDSMITH		4. DATE OF DEATH Month JULY Day 23 Year 1958	
5. SEX MALE	6. COLOR OR RACE WHITE-US	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JAN 6, 1902
9. AGE (In years last birthday) 56 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMER		10b. KIND OF BUSINESS OR INDUSTRY FARMING	
11. BIRTHPLACE (State or foreign country) MO		12. CITIZEN OF WHAT COUNTRY? USA.	
13. FATHER'S NAME BEN GOLDSMITH		14. MOTHER'S MAIDEN NAME CORA MAE LANGLEY	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. -	
17. INFORMANT Roy Goldsmith		Address WALDORF, MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ACUTE CORONARY THROMBOSIS 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) ACUTE CORONARY THROMBOSIS (5-24-58) DUE TO (c) 2 MONTHS			INTERVAL BETWEEN ONSET AND DEATH 5 HOURS
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from MAY 14 , 19 58 , to JULY 23 , 19 58 , that I last saw the deceased alive on JULY 23 , 19 58 , and that death occurred at 3:55 A.M., from the causes and on the date stated above.			
ACTUAL SIGNATURE John H. Guffey		ADDRESS (Street, city or town, state) Hughesville, MD.	
PHYSICIAN'S NAME (Type) HUNTT FUNERAL HOME		DATE SIGNED 7/23/58	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 7-26-58	22c. NAME OF CEMETERY OR CREMATORY ST MARY'S CEM.	22d. LOCATION (City, town, or county) (State) Begantown, MD.
23. FUNERAL DIRECTOR'S SIGNATURE		24a. REC'D BY REGISTRAR JUL 29 '58	
ADDRESS WALDORF, MD.		24b. REGISTRAR'S SIGNATURE W. J. ...	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1900

Page No. 1

Name of Deceased		Age		Sex		Race		Color		Religion		Marital Status		Occupation		Cause of Death		Place of Death		Date of Death		Time of Death		Signature of Physician		Signature of Registrar		Signature of Witness	
John Doe		45		Male		White		Caucasian		Roman Catholic		Single		Teacher		Heart Disease		Home		Jan 15, 1900		10:00 AM		J. B. Smith		A. C. Jones		W. E. Brown	
Place of Birth		Date of Birth		Date of Marriage		Date of Death		Date of Burial		Date of Interment		Date of Cremation		Date of Disposition		Date of Disposition		Date of Disposition		Date of Disposition		Date of Disposition		Date of Disposition		Date of Disposition		Date of Disposition	
New York		Jan 1, 1855		Jan 1, 1880		Jan 15, 1900		Jan 20, 1900		Jan 25, 1900		Jan 30, 1900		Feb 5, 1900		Feb 10, 1900		Feb 15, 1900		Feb 20, 1900		Feb 25, 1900		Feb 30, 1900		Mar 5, 1900		Mar 10, 1900	
Place of Death		Date of Death		Date of Marriage		Date of Death		Date of Burial		Date of Interment		Date of Cremation		Date of Disposition		Date of Disposition		Date of Disposition		Date of Disposition		Date of Disposition		Date of Disposition		Date of Disposition		Date of Disposition	
Home		Jan 15, 1900		Jan 1, 1880		Jan 15, 1900		Jan 20, 1900		Jan 25, 1900		Jan 30, 1900		Feb 5, 1900		Feb 10, 1900		Feb 15, 1900		Feb 20, 1900		Feb 25, 1900		Feb 30, 1900		Mar 5, 1900		Mar 10, 1900	
Cause of Death		Date of Death		Date of Marriage		Date of Death		Date of Burial		Date of Interment		Date of Cremation		Date of Disposition		Date of Disposition		Date of Disposition		Date of Disposition		Date of Disposition		Date of Disposition		Date of Disposition		Date of Disposition	
Heart Disease		Jan 15, 1900		Jan 1, 1880		Jan 15, 1900		Jan 20, 1900		Jan 25, 1900		Jan 30, 1900		Feb 5, 1900		Feb 10, 1900		Feb 15, 1900		Feb 20, 1900		Feb 25, 1900		Feb 30, 1900		Mar 5, 1900		Mar 10, 1900	
Place of Death		Date of Death		Date of Marriage		Date of Death		Date of Burial		Date of Interment		Date of Cremation		Date of Disposition		Date of Disposition		Date of Disposition		Date of Disposition		Date of Disposition		Date of Disposition		Date of Disposition		Date of Disposition	
Home		Jan 15, 1900		Jan 1, 1880		Jan 15, 1900		Jan 20, 1900		Jan 25, 1900		Jan 30, 1900		Feb 5, 1900		Feb 10, 1900		Feb 15, 1900		Feb 20, 1900		Feb 25, 1900		Feb 30, 1900		Mar 5, 1900		Mar 10, 1900	
Cause of Death		Date of Death		Date of Marriage		Date of Death		Date of Burial		Date of Interment		Date of Cremation		Date of Disposition		Date of Disposition		Date of Disposition		Date of Disposition		Date of Disposition		Date of Disposition		Date of Disposition		Date of Disposition	
Heart Disease		Jan 15, 1900		Jan 1, 1880		Jan 15, 1900		Jan 20, 1900		Jan 25, 1900		Jan 30, 1900		Feb 5, 1900		Feb 10, 1900		Feb 15, 1900		Feb 20, 1900		Feb 25, 1900		Feb 30, 1900		Mar 5, 1900		Mar 10, 1900	

RECEIVED
JAN 15 1900
BALTIMORE, MD.

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

07905

7907

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Charles</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Charles</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>LaPlata Md</u>		LENGTH OF STAY (in this place) <u>8-days</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Rural-LaPlata-Md</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Physicians Memorial Hospital</u> <u>LaPlata Md</u>				STREET ADDRESS <u>1</u>		(If rural give location)	
3. NAME OF DECEASED (Type or Print) <u>Melvin Johnson</u>				4. DATE OF DEATH (Month) <u>7</u> (Day) <u>10</u> (Year) <u>58</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH <u>10-15-57</u>		9. AGE last birthday yrs. <u>8</u> <u>5</u>		IF UNDER 1 YEAR Months <u>8</u> Days <u>5</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Charles County Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>US</u>	
13. FATHER'S NAME <u>James F. Johnson</u>				14. MOTHER'S MAIDEN NAME <u>Alice M. Proctor</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>No</u>		17. INFORMANT & ADDRESS <u>James F. Johnson, Helene Md.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
490X IMMEDIATE CAUSE (A) <u>Pneumonia - Lobar - Right Side</u>						INTERVAL BETWEEN ONSET AND DEATH <u>14-days</u>	
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO							
(C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Anemia</u>						Indefinite	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, of INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>7-2-58</u>, 19....., to <u>7-10-58</u>, 19....., that I last saw the deceased alive on <u>7-10-58</u>, 19..... and that death occurred at <u>8:30P</u> M, from the causes and on the date stated above.							
SIGNATURE <u>James F. Andrews Md</u>		ADDRESS (Street, city, town, state) <u>67-Potomac Ave-Indian Head Md</u>		DATE SIGNED <u>7-11-58</u>			
23. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		DATE THEREOF <u>7/12/58</u>		NAME OF CEMETERY OR CREMATORY <u>St. Charles</u>		LOCATION (City, town, or county) (State) <u>Indian Head, Md.</u>	
24. REC'D BY REGISTRAR <u>Jul 15 '58</u>		REGISTRAR'S SIGNATURE <u>Abner Smith</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>The South Funeral Home, Waldorf Md.</u>		ADDRESS	

4000216XV6

CERTIFICATE OF DEATH

NEW YORK STATE DEPARTMENT OF HEALTH - BUREAU OF VITAL STATISTICS

FILE NO.

1. DATE OF DEATH

2. PLACE OF DEATH

3. NAME OF DECEASED

4. SEX

5. AGE

6. OCCUPATION

7. CAUSE OF DEATH

8. MANNER OF DEATH

9. SIGNATURE OF PHYSICIAN

10. SIGNATURE OF REGISTRAR

11. SIGNATURE OF WITNESSES

12. SIGNATURE OF DECEASED

13. SIGNATURE OF FUNERAL HOME

14. SIGNATURE OF BURIAL SOCIETY

15. SIGNATURE OF OTHER

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1. PLACE OF DEATH

2. NAME OF DECEASED

3. SEX

4. AGE

5. OCCUPATION

6. CAUSE OF DEATH

7. MANNER OF DEATH

8. SIGNATURE OF PHYSICIAN

9. SIGNATURE OF REGISTRAR

10. SIGNATURE OF WITNESSES

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12. SIGNATURE OF FUNERAL HOME

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TO BUREAU OF VITAL STATISTICS
TO BUREAU OF HEALTH
TO BUREAU OF EDUCATION
TO BUREAU OF AGRICULTURE
TO BUREAU OF COMMERCE
TO BUREAU OF LABOR
TO BUREAU OF MINES
TO BUREAU OF NAVY
TO BUREAU OF WAR
TO BUREAU OF AIR FORCE
TO BUREAU OF MARINE CORPS
TO BUREAU OF COAST AND GEODETIC SURVEY
TO BUREAU OF GEOLOGICAL SURVEY
TO BUREAU OF INDIAN AFFAIRS
TO BUREAU OF LAND OFFICE
TO BUREAU OF PATENT OFFICE
TO BUREAU OF POST OFFICE
TO BUREAU OF PRISON
TO BUREAU OF PUBLIC WORKS
TO BUREAU OF RAILROADS
TO BUREAU OF REVENUE
TO BUREAU OF SHIPPING
TO BUREAU OF SHERIFFS
TO BUREAU OF STATE DEPARTMENT
TO BUREAU OF STATE TREASURY
TO BUREAU OF SUPPLY
TO BUREAU OF TARIFFS
TO BUREAU OF VETERANS AFFAIRS
TO BUREAU OF WEAPONS
TO BUREAU OF WILDERNESS SERVICE
TO BUREAU OF ZOOLOGICAL GARDEN

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained in your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(9)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

7908

07906

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Charles MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Charles			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Indian Head				c. LENGTH OF STAY IN 1b 2 mos.			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) U.S. Navy Dispensary, Indian Head				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Indian Head			
f. 15 RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First SUE Middle OWENS Last OWENS				4. DATE OF DEATH Month July Day 13 Year 1958			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept. 1, 1940	
9. AGE (In years last birthday) 17 yrs.		10. UNDER 1 YEAR Months 17 Days 13 Hours 13 Min.		11. BIRTHPLACE (State or foreign country) Louisa, Kentucky		12. CITIZEN OF WHAT COUNTRY? U.S.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk.				10b. KIND OF BUSINESS OR INDUSTRY Drug Store			
13. FATHER'S NAME Obrian Owens				14. MOTHER'S MAIDEN NAME Dorothy Looney			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO				16. SOCIAL SECURITY NO. 055-56-2079			
17. INFORMANT John R. Horn, Indian Head, Md. (Stepfather)				Address Indian Head, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1. Multiple External Injuries, Extremities							
812X DUE TO (b) 2. Compound fractures both lower extremities with traumatic amputation Right leg							
Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. Interval between onset and death 5 minutes							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 812X							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Deceased was walking on highway when struck by a car			
20c. TIME OF INJURY Month, Day, Year 7/13/58		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Rt 210 near		20f. (City or town) Indian Head Charles (County) Charles (State) Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE Frank A. Susan				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) Frank A. Susan M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 7/13/58		22c. NAME OF CEMETERY OR CREMATORY Oak Hill	
23. FUNERAL DIRECTOR'S SIGNATURE Richard And Laplala				ADDRESS Indian Head, Md.		24. REC'D BY REGISTRAR W. H. Smith	
				24b. REGISTRAR'S SIGNATURE		24c. DATE JUL 16 '58	

DATE SIGNED

July 13, 1958

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 12
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. DEATH CERTIFICATE NUMBER		2. DATE OF DEATH	
3. TIME OF DEATH		4. PLACE OF DEATH	
5. NAME OF DECEASED		6. SEX	
7. AGE		8. RACE	
9. OCCUPATION		10. MARITAL STATUS	
11. CAUSE OF DEATH		12. MANNER OF DEATH	
13. SIGNATURE OF EXAMINER		14. SIGNATURE OF WITNESS	
15. SIGNATURE OF CORONER		16. SIGNATURE OF JURY	
17. SIGNATURE OF MEDICAL EXAMINER		18. SIGNATURE OF JURY	
19. SIGNATURE OF JURY		20. SIGNATURE OF JURY	
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INSTRUCTIONS

TO ATTENDING PHYSICIAN OF HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

07907

7909

CERTIFICATE OF DEATH

Reg. Dist. No.....

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
CITY <u>Indian Head Md</u> <u>Charles</u> MARYLAND				STATE <u>Maryland</u> COUNTY <u>Charles</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Indian Head Md</u>				CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>X</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>None</u>				STREET ADDRESS (If rural give location) <u>1</u>			
3. NAME OF DECEASED (First) (Middle) (Last) <u>Vincent McKinley Proctor</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>7-25-58</u> <u>19</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH <u>12-30-57</u>	9. AGE last birthday yrs. <u>6</u>	IF UNDER 1 YEAR Months <u>6</u> Days <u>25</u>	IF UNDER 24 HRS. Hours <u>19</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Indian Head Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>US</u>
13. FATHER'S NAME <u>Walter Proctor</u>				14. MOTHER'S MAIDEN NAME <u>Shirley Proctor</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>No</u>			16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT & ADDRESS <u>Agnes Proctor-Grand-Mother, Indian Head</u>		
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
490X IMMEDIATE CAUSE (A) <u>Pneumonia lobar</u>						INTERVAL BETWEEN ONSET AND DEATH <u>5-days</u>	
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) <u>DUE TO</u>							
(C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION				19b. MAJOR FINDINGS OF OPERATION			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) <u>Indian Head Md</u>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.) <u>M.</u>				21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> el work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>7-23-58</u>, 19<u>58</u>, to <u>7-25-58</u>, 19<u>58</u>, that I last saw the deceased alive on <u>7-23-58</u>, 19<u>58</u>, and that death occurred at <u>2-15PM</u> from the causes and on the date stated above.							
SIGNATURE <u>James E. Andrews MD</u>				ADDRESS (Street, city, town, state) <u>M.D. Indian Head Md</u>			
DATE SIGNED <u>7-25-58</u>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>7/26/58</u>		NAME OF CEMETERY OR CREMATORY <u>St Joseph</u>		LOCATION (City, town, or county) (State) <u>Pomfret Md</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>Robert McLeoplate MD</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Robert McLeoplate MD</u>		ADDRESS	
DATE <u>JUL 31 58</u>							

4000181XV

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07908

Reg. Dist. No.

7910

FOR STATE
HEALTH DEPT.

M

1. PLACE OF DEATH a. COUNTY <u>Charles</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Charles</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>La Plata</u>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Newburg</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Physician's Memorial Hospital</u>				d. STREET ADDRESS <u>1</u>			
3. NAME OF DECEASED (Type or print) First <u>Charles</u> Middle <u>Lee</u> Last <u>Rich</u>				4. DATE OF DEATH Month <u>July</u> Day <u>5</u> Year <u>1958</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 9, 1884</u>	9. AGE (In years last birthday) <u>74</u> yrs.	IF UNDER 1 YEAR Months <u>7</u> Days <u>1</u> Hours <u>1</u> Min.		IF UNDER 24 HRS. Hours <u>1</u> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Interior Dec.</u>		11. BIRTHPLACE (State or foreign country) <u>North Carolina</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>David Rich</u>				14. MOTHER'S MAIDEN NAME <u>Roxann Bennett</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>23705-66851</u>		17. INFORMANT <u>Maude Rich</u> Address <u>Newburg, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebro Vas. Accident</u> <u>331X</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Hypertension</u> (c) <u>331X</u> DUE TO (c) <u>331X</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>331X</u>						INTERVAL BETWEEN ONSET AND DEATH <u>7-4-58</u> <u>?</u>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour <u>a. m.</u> <u>19</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>E. J. Edelen</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>Edward J. Edelen, Md. D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>7-8-58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Lee Chapel</u>	
				22d. LOCATION (City, town, or county) <u>Greensboro, N.C.</u>		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Richard Mc Lepata</u>				24a. REC'D BY REGISTRAR <u>Jul 10 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Richard Mc Lepata</u>	

STATE OF
NEW YORK

1910

NEW YORK STATE DEPARTMENT OF HEALTH - BUREAU OF
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. OCCUPATION	
5. PLACE OF BIRTH		6. DATE OF BIRTH		7. DATE OF DEATH		8. PLACE OF DEATH	
9. CAUSE OF DEATH		10. MANNER OF DEATH		11. MEDICAL HISTORY		12. POST-MORTEM EXAMINATION	
13. SIGNATURE OF MEDICAL EXAMINER		14. SIGNATURE OF WITNESS		15. SIGNATURE OF CORONER		16. SIGNATURE OF JURY	
17. SIGNATURE OF DECEASED		18. SIGNATURE OF NEXT OF KIN		19. SIGNATURE OF CLERGYMAN		20. SIGNATURE OF OTHER	
21. SIGNATURE OF MEDICAL EXAMINER		22. SIGNATURE OF WITNESS		23. SIGNATURE OF CORONER		24. SIGNATURE OF JURY	
25. SIGNATURE OF DECEASED		26. SIGNATURE OF NEXT OF KIN		27. SIGNATURE OF CLERGYMAN		28. SIGNATURE OF OTHER	
29. SIGNATURE OF MEDICAL EXAMINER		30. SIGNATURE OF WITNESS		31. SIGNATURE OF CORONER		32. SIGNATURE OF JURY	
33. SIGNATURE OF DECEASED		34. SIGNATURE OF NEXT OF KIN		35. SIGNATURE OF CLERGYMAN		36. SIGNATURE OF OTHER	
37. SIGNATURE OF MEDICAL EXAMINER		38. SIGNATURE OF WITNESS		39. SIGNATURE OF CORONER		40. SIGNATURE OF JURY	
41. SIGNATURE OF DECEASED		42. SIGNATURE OF NEXT OF KIN		43. SIGNATURE OF CLERGYMAN		44. SIGNATURE OF OTHER	
45. SIGNATURE OF MEDICAL EXAMINER		46. SIGNATURE OF WITNESS		47. SIGNATURE OF CORONER		48. SIGNATURE OF JURY	
49. SIGNATURE OF DECEASED		50. SIGNATURE OF NEXT OF KIN		51. SIGNATURE OF CLERGYMAN		52. SIGNATURE OF OTHER	
53. SIGNATURE OF MEDICAL EXAMINER		54. SIGNATURE OF WITNESS		55. SIGNATURE OF CORONER		56. SIGNATURE OF JURY	
57. SIGNATURE OF DECEASED		58. SIGNATURE OF NEXT OF KIN		59. SIGNATURE OF CLERGYMAN		60. SIGNATURE OF OTHER	
61. SIGNATURE OF MEDICAL EXAMINER		62. SIGNATURE OF WITNESS		63. SIGNATURE OF CORONER		64. SIGNATURE OF JURY	
65. SIGNATURE OF DECEASED		66. SIGNATURE OF NEXT OF KIN		67. SIGNATURE OF CLERGYMAN		68. SIGNATURE OF OTHER	
69. SIGNATURE OF MEDICAL EXAMINER		70. SIGNATURE OF WITNESS		71. SIGNATURE OF CORONER		72. SIGNATURE OF JURY	
73. SIGNATURE OF DECEASED		74. SIGNATURE OF NEXT OF KIN		75. SIGNATURE OF CLERGYMAN		76. SIGNATURE OF OTHER	
77. SIGNATURE OF MEDICAL EXAMINER		78. SIGNATURE OF WITNESS		79. SIGNATURE OF CORONER		80. SIGNATURE OF JURY	
81. SIGNATURE OF DECEASED		82. SIGNATURE OF NEXT OF KIN		83. SIGNATURE OF CLERGYMAN		84. SIGNATURE OF OTHER	
85. SIGNATURE OF MEDICAL EXAMINER		86. SIGNATURE OF WITNESS		87. SIGNATURE OF CORONER		88. SIGNATURE OF JURY	
89. SIGNATURE OF DECEASED		90. SIGNATURE OF NEXT OF KIN		91. SIGNATURE OF CLERGYMAN		92. SIGNATURE OF OTHER	
93. SIGNATURE OF MEDICAL EXAMINER		94. SIGNATURE OF WITNESS		95. SIGNATURE OF CORONER		96. SIGNATURE OF JURY	
97. SIGNATURE OF DECEASED		98. SIGNATURE OF NEXT OF KIN		99. SIGNATURE OF CLERGYMAN		100. SIGNATURE OF OTHER	

7911

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Charles MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Charles	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) La Plata		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Physicians Memorial Hospital		d. STREET ADDRESS Waldorf	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First RONALD Middle STEVEN Last Riley		4. DATE OF DEATH Month July Day 21 Year 1958	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 21 July 58
9. AGE (In years last birthday) yrs. 7 Months 4 Days 10 Min.		IF UNDER 1 YEAR IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Infant		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Douglas Fairbanks Riley		14. MOTHER'S MAIDEN NAME Helen Luree Moreland	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO.	
17. INFORMANT Mrs. Helen Marx M. Riley, Waldorf, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory Collapse 762.5 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) prematurity DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 1 hr	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 21 July 1958 , to 21 July 1958 , that I last saw the deceased alive on 21 July 1958 , and that death occurred at 12:00 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Arthur O. Wooddy M.D.		ADDRESS (Street, city or town, state) LA PLATA DATE SIGNED 21 July 58	
PHYSICIAN'S NAME (Type) ARTHUR O. WOODDY, MD. Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 7-22-58	
22c. NAME OF CEMETERY OR CREMATORY OAKLAND		22d. LOCATION (City, town, or county) (State) WALDORF, MD.	
23. FUNERAL DIRECTOR'S SIGNATURE HUNT FUNERAL HOME		ADDRESS WALDORF, MD.	
24a. REC'D BY REGISTRAR DATE JUL 23 '58		24b. REGISTRAR'S SIGNATURE Art Leach	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. Name of deceased		2. Sex		3. Age	
4. Date of death		5. Time of death		6. Place of death	
7. Cause of death		8. Manner of death		9. Signature of physician	
10. Signature of registrar		11. Signature of coroner		12. Signature of undertaker	
13. Signature of witness		14. Signature of witness		15. Signature of witness	
16. Signature of witness		17. Signature of witness		18. Signature of witness	
19. Signature of witness		20. Signature of witness		21. Signature of witness	
22. Signature of witness		23. Signature of witness		24. Signature of witness	
25. Signature of witness		26. Signature of witness		27. Signature of witness	
28. Signature of witness		29. Signature of witness		30. Signature of witness	
31. Signature of witness		32. Signature of witness		33. Signature of witness	
34. Signature of witness		35. Signature of witness		36. Signature of witness	
37. Signature of witness		38. Signature of witness		39. Signature of witness	
40. Signature of witness		41. Signature of witness		42. Signature of witness	
43. Signature of witness		44. Signature of witness		45. Signature of witness	
46. Signature of witness		47. Signature of witness		48. Signature of witness	
49. Signature of witness		50. Signature of witness		51. Signature of witness	
52. Signature of witness		53. Signature of witness		54. Signature of witness	
55. Signature of witness		56. Signature of witness		57. Signature of witness	
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64. Signature of witness		65. Signature of witness		66. Signature of witness	
67. Signature of witness		68. Signature of witness		69. Signature of witness	
70. Signature of witness		71. Signature of witness		72. Signature of witness	
73. Signature of witness		74. Signature of witness		75. Signature of witness	
76. Signature of witness		77. Signature of witness		78. Signature of witness	
79. Signature of witness		80. Signature of witness		81. Signature of witness	
82. Signature of witness		83. Signature of witness		84. Signature of witness	
85. Signature of witness		86. Signature of witness		87. Signature of witness	
88. Signature of witness		89. Signature of witness		90. Signature of witness	
91. Signature of witness		92. Signature of witness		93. Signature of witness	
94. Signature of witness		95. Signature of witness		96. Signature of witness	
97. Signature of witness		98. Signature of witness		99. Signature of witness	
100. Signature of witness		101. Signature of witness		102. Signature of witness	

ALL INFORMATION CONTAINED HEREIN IS UNCLASSIFIED

CERTIFICATE OF DEATH

07910

Reg. Dist. No.

7912

1. PLACE OF DEATH a. COUNTY <u>Charles</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>La Plata</u>		c. LENGTH OF STAY IN 1b <u>3 Days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Physicians Memorial Hosp</u>		d. STREET ADDRESS <u>Brandywine 16 X 2</u>	
3. NAME OF DECEASED (Type or print) <u>Arzillo V. Robey</u> Middle Last		4. DATE OF DEATH <u>July 3 1958</u> Month Day Year	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb 17 1879</u> 79 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Gwynn Davis</u>		14. MOTHER'S MAIDEN NAME <u>?</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>Ralph Robey, Brandywine, Md.</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction</u> DUE TO <u>Arteriosclerotic Heart Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (c) <u>years</u>		INTERVAL BETWEEN ONSET AND DEATH <u>30 min</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Acute Bilateral Pneumonia</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>no injury</u>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>7-1</u> <u>1958</u> , to <u>7-3</u> <u>1958</u> , that I last saw the deceased alive on <u>7-1</u> <u>1958</u> , and that death occurred at <u>8:50 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>V.B. Detlor</u>		ADDRESS (Street, city or town, state) <u>LA PLATA, MD.</u> DATE SIGNED <u>7-3-58</u>	
PHYSICIAN'S NAME (Type) <u>V.B. DETTOR</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>7/5/58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>St Pauls</u>		22d. LOCATION (City, town, or county) (State) <u>Waldorf, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>The Hunt Funeral Home, Waldorf, Md.</u> ADDRESS		24a. REC'D BY REGISTRAR <u>Jul 8 58</u> DATE	
		24b. REGISTRAR'S SIGNATURE <u>Arzillo</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Form No. 1

DECEASED

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

MANNER OF DEATH

AGE AT DEATH

SEX

RACE

EDUCATION

OCCUPATION

RELIGION

DATE OF BIRTH

PLACE OF BIRTH

DATE OF ENTRY

PLACE OF ENTRY

DATE OF DEPARTURE

PLACE OF DEPARTURE

DATE OF RETURN

PLACE OF RETURN

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

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PLACE OF DEATH

DATE OF DEATH

PLACE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										07911
7913										CERTIFICATE OF DEATH
Reg. Dist. No.										
1. PLACE OF DEATH o. COUNTY CHARLES MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md. b. COUNTY Ches					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) La Plata			c. LENGTH OF STAY IN 1b 2 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - HUGHESVILLE.					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION PHYSICIANS MEMORIAL HOSP					d. STREET ADDRESS			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First CHARLOTTE Middle SHIRRIEL Last SHIRRIEL					4. DATE OF DEATH Month July Day 25 Year 1958					
5. SEX Female		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Jan. 10 1955		9. AGE (In years last birthday) 3 yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Md.			12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Nathaniel Shirriel					14. MOTHER'S MARRIED NAME Catherine Shirriel					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. —		17. INFORMANT Name Catherine Shirriel Address Hughesville Md.						
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory paralysis 927.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Cerebral edema DUE TO (c) Snake bite INTERVAL BETWEEN ONSET AND DEATH 6 hrs. 1 day. 2 days.										
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										
20a. ACCIDENT WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Snake bit child in the left leg twice while she was playing in an empty corn crib.					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19					20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Farm		20f. (City or town) (County) (State) Hughesville Ches. Maryland	
21. I certify that I attended the deceased from 23 July 1958 , to 25 July 1958 , that I last saw the deceased alive on 25 July 1958 , and that death occurred at 5:30 A.M. from the causes and on the date stated above.										
ACTUAL SIGNATURE A. Woody					ADDRESS (Street, city or town, state) La Plata Md.					
PHYSICIAN'S NAME (Type) ARTHUR O. WOODY					DATE SIGNED 25 July 58					
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY			22d. LOCATION (City, town, or county) (State)			
Burial		July 27 1958		St. Marys			Bryantown Md.			
23. FUNERAL DIRECTOR'S SIGNATURE Arthur O. Woody					ADDRESS Home, La Plata Md.		24a. REC'D BY REGISTRAR DATE JUL 30 '58		24b. REGISTRAR'S SIGNATURE Arthur O. Woody	

100

10

1890

U. S. 127 21 24

7914

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Items 11, 12, 13, 14 Film G232 8-18-58 et

Reg. Dist. No.

07912

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the City Medical Examiner's Office along with form PNG. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, at its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 2/57

1. PLACE OF DEATH a. COUNTY Charles MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mason Springs c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Mattawoman Creek		2. USUAL RESIDENCE (Place deceased lived. If institution: Residence before admission) a. STATE Colorado Colorado b. COUNTY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Grand Junction d. STREET ADDRESS La Plata, Maryland e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) JOHN L. STALKER First Middle Last 5. SEX Male 6. COLOR OR RACE White 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH 5-22-1939 9. AGE (In years last birthday) 19 yrs. 10. IF UNDER 1 YEAR Months Days 11. IF UNDER 24 HRS. Hours Min. 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Soldier 10b. KIND OF BUSINESS OR INDUSTRY U.S. Army 11. BIRTHPLACE (State or foreign country) Grand Junction, Colo. 12. CITIZEN OF WHAT COUNTRY? U.S.A. 13. FATHER'S NAME John S. Stalker 14. MOTHER'S MAIDEN NAME Unknown 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes 16. SOCIAL SECURITY NO. 17. INFORMANT Address		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Drowning, found drowned. 929.8 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Undetermined 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Creek 20f. (City or town) Mason Springs, (County) Chas. (State) Md.		21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/> ACTUAL SIGNATURE <i>Paul F. Guerin</i> M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) Paul F. Guerin, M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 7-25-58	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL 22b. DATE THEREOF AUG. 27, 1958 22c. NAME OF CEMETERY OR CREMATORY GRAND JUNCTION, COLORADO 22d. LOCATION (City, town, or county) (State)		23. FUNERAL DIRECTOR'S SIGNATURE <i>Edwards</i> ADDRESS Edwards Funeral Home Inc 516 H St. WASH. 2, D.C. 24a. REC'D BY REGISTRAR DATE AUG 4 '58 24b. REGISTRAR'S SIGNATURE <i>W. J. ...</i>	

Figure 3.0

7915 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Chas.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Char les</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bel Alton</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bel Alton</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>St. Mary's Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
NAME OF DECEASED (Type or print) <u>Baby Girl</u> First <u>Swann</u> Middle <u>Swann</u> Last <u>Swann</u>		4. DATE OF DEATH <u>July 11</u> Month <u>11</u> Day <u>1958</u> Year	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 11, 1958</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (State or foreign country) <u>Charles Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>James D Swann</u>		14. MOTHER'S MAIDEN NAME <u>Agnes C. Hankins</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>James D Swann Bel Alton</u>	
17. INFORMANT <u>James D Swann Bel Alton</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory collapse</u> <u>762.5</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Prematurity</u> DUE TO (c) <u>18 hrs.</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 hour.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>18 hrs.</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. <u>19</u> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>7-11</u> , 19 <u>58</u> , to <u>7-11</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>7-11</u> , 19 <u>58</u> , and that death occurred at <u>2:30 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>F M Johnson</u> M.D.		DATE SIGNED <u>7-12-58</u>	
PHYSICIAN'S NAME (Type) <u>F M Johnson M.D.</u>		ADDRESS (Street, city or town, state)	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <u>July 12, 58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Family Burial Ground</u>	22d. LOCATION (City, town, or county) (State) <u>Bel Alton Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles Mc Laflata</u>		24a. REC'D BY REGISTRAR <u>Jul 16 '58</u> DATE	
24b. REGISTRAR'S SIGNATURE <u>W. H. Smith</u>			

CERTIFICATE OF DEATH

1. NAME OF DECEASED <i>John Doe</i>		2. SEX <i>Male</i>		3. AGE <i>45</i>	
4. DATE OF DEATH <i>Jan 15 1923</i>		5. TIME OF DEATH <i>10:30 AM</i>		6. PLACE OF DEATH <i>Home</i>	
7. CAUSE OF DEATH <i>Heart Disease</i>		8. DISEASE OR INJURY <i>Myocardial Infarction</i>		9. MANNER OF DEATH <i>Natural</i>	
10. SIGNATURE OF PHYSICIAN <i>Dr. J. H. Smith</i>		11. SIGNATURE OF WITNESSES <i>John Doe, Jr.</i> <i>Mary Doe</i>		12. SIGNATURE OF CORONER <i>John Doe</i>	
13. PLACE OF BIRTH <i>Baltimore, Md.</i>		14. OCCUPATION <i>Teacher</i>		15. MARITAL STATUS <i>Married</i>	
16. EDUCATION <i>High School</i>		17. RELIGION <i>Methodist</i>		18. US BIRTH <i>Yes</i>	
19. US CITIZENSHIP <i>Yes</i>		20. COLOR <i>White</i>		21. HEIGHT <i>5' 8"</i>	
22. WEIGHT <i>150 lbs</i>		23. BUILD <i>Medium</i>		24. COMPLEXION <i>Fair</i>	
25. HAIR <i>Dark</i>		26. EYES <i>Blue</i>		27. MOUTH <i>Normal</i>	
28. TEETH <i>Good</i>		29. NOSE <i>Normal</i>		30. SKIN <i>Good</i>	
31. FINGER <i>Good</i>		32. TOE <i>Good</i>		33. HEEL <i>Good</i>	
34. PALM <i>Good</i>		35. SOLE <i>Good</i>		36. HEEL <i>Good</i>	
37. FINGER <i>Good</i>		38. TOE <i>Good</i>		39. HEEL <i>Good</i>	
40. PALM <i>Good</i>		41. SOLE <i>Good</i>		42. HEEL <i>Good</i>	

THE DEPARTMENT OF HEALTH, BALTIMORE, MARYLAND, RECEIVED THIS *15* DAY OF *JAN* 19*23*

AD. J. H. SMITH, M.D., PHYSICIAN

JOHN DOE, JR., WITNESS

MARY DOE, WITNESS

JOHN DOE, CORONER

7916

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <i>Charles</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>md</i> b. COUNTY <i>Charles</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>La Plata</i>	c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>La Plata md</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <i>1</i>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <i>ANNIE</i> First <i>ELSIE</i> Middle <i>THOMAS</i> Last		4. DATE OF DEATH Month <i>July</i> Day <i>10</i> Year <i>1958</i>	
5. SEX <i>F</i>	6. COLOR OR RACE <i>C</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>April 21, 1914</i>
9. AGE (In years last birthday) <i>44</i> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>H. W.</i>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>usa</i>	
13. FATHER'S NAME <i>John H. Proctor</i>		14. MOTHER'S MAIDEN NAME <i>Mary C. Butler</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <i>John Henry Thomas LaPlata</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute Cardiac dilatation</i> <i>434.4</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Cardiac failure, chronic</i> DUE TO (c) <i>2 years</i>		INTERVAL BETWEEN ONSET AND DEATH <i>instant</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>June</i> , 19 <i>57</i> , to <i>10 July</i> , 19 <i>58</i> , that I last saw the deceased alive on <i>8 July</i> , 19 <i>58</i> , and that death occurred at <i>5:30 P.M.</i> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>F. Johnson</i>		DATE SIGNED <i>La Plata MD. 10 July 58</i>	
PHYSICIAN'S NAME (Type) <i>F. JOHNSON M.D.</i>		<i>LA. PLATA, MARYLAND</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <i>7/14/58</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Good Heart Cemetery</i>	22d. LOCATION (City, town, or county) (State) <i>La Plata md</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Charters Inc LaPlata</i>		24. RECORD BY REGISTRAR <i>DATE JUL 16 '58</i>	
		24b. REGISTRAR'S SIGNATURE <i>Overman</i>	

7917

CERTIFICATE OF DEATH

Item 13, See: Birth Cert., et

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Charles</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>md</u> b. COUNTY <u>CHAS</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Mt Victoria</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Mt Victoria</u>	
c. LENGTH OF STAY IN 1b <u>1 wk</u>		d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Physicians Mem Hosp</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>ELSIE MAY THOMAS</u>		4. DATE OF DEATH Month Day Year <u>July 9 1958</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 10, 1957</u>
9. AGE (In years last birthday) yrs. Months Days <u>11 29</u>		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>James R. Thomas</u>		14. MOTHER'S MAIDEN NAME <u>Agnes M Miles</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>James R Thomas</u>		Address <u>Mt Victoria Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>571.0 generalized septicaemia</u> DUE TO (b) <u>respiratory infection</u> DUE TO (c) <u>diarrhea</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Mongolianism</u>			INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u> <u>1 week</u> <u>1 week</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>7-2-58</u> , 19 <u>58</u> , to <u>7-9-58</u> , that I last saw the deceased alive on <u>7-8-58</u> , 19 <u>58</u> , and that death occurred at <u>5:50 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>F Johnson</u> M.D.		ADDRESS (Street, city or town, state) <u>LAPLATA Md</u> DATE SIGNED <u>7-9-58</u>	
PHYSICIAN'S NAME (Type) <u>F Johnson md</u>		<u>LAPLATA md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>7-10-58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Holy Ghost</u>	22d. LOCATION (City, town, or county) (State) <u>md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Hunt Funeral Home</u> ADDRESS <u>Waldorf Md</u>		24a. REC'D BY REGISTRAR <u>DATE JUL 14 '58</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur</u>

4000419xv6

CERTIFICATE OF DEATH

NAME OF DECEASED
RESIDENCE
DATE OF DEATH
PLACE OF DEATH
CAUSE OF DEATH

AGE
SEX
MARRIAGE
OCCUPATION
EDUCATION

PREVIOUS ILLNESS
TREATMENT
HISTORY

TESTIMONY OF PHYSICIAN
TESTIMONY OF WITNESSES

SIGNATURE OF PHYSICIAN
SIGNATURE OF WITNESSES
DATE OF SIGNATURE

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7918

CERTIFICATE OF DEATH

07916

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Charles MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Charles			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Nanjemoy				c. LENGTH OF STAY IN 1b Lifetime			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS X Nanjemoy			
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) JOHN First ROBERT Middle THOMPSON Last				4. DATE OF DEATH Month July Day 26 Year 19 58			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH December 15, 1875	9. AGE (In years last birthday) 82 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY On own Farm		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Walter M. Thompson				14. MOTHER'S MAIDEN NAME Maria Robey			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Mrs. Pearl F. Jones 1420 S. Street S. E. Washington, D.C.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypertensive Heart Disease DUE TO Anemina? Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 2 Years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Old Age							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from May 1956 to July 26 1958 , that I last saw the deceased alive on July 20 1958 , and that death occurred at 10 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Frank A. Susan Indian Head, Maryland 7/26/58							
ACTUAL SIGNATURE Frank A. Susan				PHYSICIAN'S NAME (Type) Frank A. Susan			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/28/ 1958		22c. NAME OF CEMETERY OR CREMATORY Nanjemoy Baptist Cemetery		22d. LOCATION (City, town, or county) (State) Nanjemoy, Charles, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE F. H. Inc. ADDRESS Archway Funeral Home Inc. La Plata, Maryland				24a. REC'D BY REGISTRAR DATE 8/11 31 '58		24b. REGISTRAR'S SIGNATURE Overhouch	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, pages 1 and 2 should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED JOHN ROBERTSON		2. SEX Male		3. AGE 45	
4. DATE OF DEATH July 10, 1955		5. TIME OF DEATH 10:30 AM		6. PLACE OF DEATH Home	
7. CAUSE OF DEATH Myocardial Infarction		8. MANNER OF DEATH Natural		9. SIGNATURE OF PHYSICIAN J. A. Smith	
10. SIGNATURE OF REGISTRAR M. J. Jones		11. SIGNATURE OF WITNESSES J. A. Smith, M. J. Jones		12. SIGNATURE OF DECEASED John Robertson	
13. SIGNATURE OF NEAREST RELATIVE Mrs. Mary Robertson		14. SIGNATURE OF CLERK M. J. Jones		15. SIGNATURE OF DECEASED John Robertson	
16. SIGNATURE OF DECEASED John Robertson		17. SIGNATURE OF DECEASED John Robertson		18. SIGNATURE OF DECEASED John Robertson	
19. SIGNATURE OF DECEASED John Robertson		20. SIGNATURE OF DECEASED John Robertson		21. SIGNATURE OF DECEASED John Robertson	
22. SIGNATURE OF DECEASED John Robertson		23. SIGNATURE OF DECEASED John Robertson		24. SIGNATURE OF DECEASED John Robertson	
25. SIGNATURE OF DECEASED John Robertson		26. SIGNATURE OF DECEASED John Robertson		27. SIGNATURE OF DECEASED John Robertson	
28. SIGNATURE OF DECEASED John Robertson		29. SIGNATURE OF DECEASED John Robertson		30. SIGNATURE OF DECEASED John Robertson	
31. SIGNATURE OF DECEASED John Robertson		32. SIGNATURE OF DECEASED John Robertson		33. SIGNATURE OF DECEASED John Robertson	
34. SIGNATURE OF DECEASED John Robertson		35. SIGNATURE OF DECEASED John Robertson		36. SIGNATURE OF DECEASED John Robertson	
37. SIGNATURE OF DECEASED John Robertson		38. SIGNATURE OF DECEASED John Robertson		39. SIGNATURE OF DECEASED John Robertson	
40. SIGNATURE OF DECEASED John Robertson		41. SIGNATURE OF DECEASED John Robertson		42. SIGNATURE OF DECEASED John Robertson	
43. SIGNATURE OF DECEASED John Robertson		44. SIGNATURE OF DECEASED John Robertson		45. SIGNATURE OF DECEASED John Robertson	
46. SIGNATURE OF DECEASED John Robertson		47. SIGNATURE OF DECEASED John Robertson		48. SIGNATURE OF DECEASED John Robertson	
49. SIGNATURE OF DECEASED John Robertson		50. SIGNATURE OF DECEASED John Robertson		51. SIGNATURE OF DECEASED John Robertson	
52. SIGNATURE OF DECEASED John Robertson		53. SIGNATURE OF DECEASED John Robertson		54. SIGNATURE OF DECEASED John Robertson	
55. SIGNATURE OF DECEASED John Robertson		56. SIGNATURE OF DECEASED John Robertson		57. SIGNATURE OF DECEASED John Robertson	
58. SIGNATURE OF DECEASED John Robertson		59. SIGNATURE OF DECEASED John Robertson		60. SIGNATURE OF DECEASED John Robertson	
61. SIGNATURE OF DECEASED John Robertson		62. SIGNATURE OF DECEASED John Robertson		63. SIGNATURE OF DECEASED John Robertson	
64. SIGNATURE OF DECEASED John Robertson		65. SIGNATURE OF DECEASED John Robertson		66. SIGNATURE OF DECEASED John Robertson	
67. SIGNATURE OF DECEASED John Robertson		68. SIGNATURE OF DECEASED John Robertson		69. SIGNATURE OF DECEASED John Robertson	
70. SIGNATURE OF DECEASED John Robertson		71. SIGNATURE OF DECEASED John Robertson		72. SIGNATURE OF DECEASED John Robertson	
73. SIGNATURE OF DECEASED John Robertson		74. SIGNATURE OF DECEASED John Robertson		75. SIGNATURE OF DECEASED John Robertson	
76. SIGNATURE OF DECEASED John Robertson		77. SIGNATURE OF DECEASED John Robertson		78. SIGNATURE OF DECEASED John Robertson	
79. SIGNATURE OF DECEASED John Robertson		80. SIGNATURE OF DECEASED John Robertson		81. SIGNATURE OF DECEASED John Robertson	
82. SIGNATURE OF DECEASED John Robertson		83. SIGNATURE OF DECEASED John Robertson		84. SIGNATURE OF DECEASED John Robertson	
85. SIGNATURE OF DECEASED John Robertson		86. SIGNATURE OF DECEASED John Robertson		87. SIGNATURE OF DECEASED John Robertson	
88. SIGNATURE OF DECEASED John Robertson		89. SIGNATURE OF DECEASED John Robertson		90. SIGNATURE OF DECEASED John Robertson	
91. SIGNATURE OF DECEASED John Robertson		92. SIGNATURE OF DECEASED John Robertson		93. SIGNATURE OF DECEASED John Robertson	
94. SIGNATURE OF DECEASED John Robertson		95. SIGNATURE OF DECEASED John Robertson		96. SIGNATURE OF DECEASED John Robertson	
97. SIGNATURE OF DECEASED John Robertson		98. SIGNATURE OF DECEASED John Robertson		99. SIGNATURE OF DECEASED John Robertson	
100. SIGNATURE OF DECEASED John Robertson		101. SIGNATURE OF DECEASED John Robertson		102. SIGNATURE OF DECEASED John Robertson	



RECEIVED
JUL 11 1955
BALTIMORE, MD

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing it and "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the County Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 2/57

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7919 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

07918

1. PLACE OF DEATH a. COUNTY <u>Charles</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Unknown</u> b. COUNTY <u>Unknown</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Waldorf</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Unknown</u>	
c. LENGTH OF STAY IN 1b <u>Unknown</u>		d. STREET ADDRESS <u>Unknown</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>none</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Unknown</u>		4. DATE OF DEATH <u>Unknown-7-30-58??</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W??</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Unknown-7-20-58??</u> yrs.
9. AGE (In years last birthday) <u>3</u> yrs.		10. IF UNDER 1 YEAR Months <u>—</u> Days <u>10</u>	
11. IF UNDER 24 HRS. Hours <u>—</u> Min. <u>—</u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>—</u>	
10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State of foreign country) <u>Unknown</u>	
12. CITIZEN OF WHAT COUNTRY? <u>Unknown</u>		13. FATHER'S NAME <u>Unknown</u>	
14. MOTHER'S MAIDEN NAME <u>Unknown</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>	
16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>none</u> Address <u>—</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Abandonment</u> <u>983X</u> DUE TO (b) <u>Death from causes undeterminable, unknown</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>—</u>		INTERVAL BETWEEN ONSET AND DEATH <u>Unknown</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>No autopsy due to lack of material.</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. <u>—</u>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>—</u>	
20c. TIME OF INJURY Month, Day, Year <u>Unknown</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>—</u>	20f. (City or town) (County) (State) <u>Waldorf MD</u>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input checked="" type="checkbox"/>			
ACTUAL SIGNATURE <u>V. B. Dettor</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>V. B. DETTOR</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
ACTING DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>8/4/58</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>8/4/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>St Pauls</u>	22d. LOCATION (City, town, or county) (State) <u>Waldorf MD</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>The Hunt Funeral Home, Waldorf, Md.</u>		24a. REC'D BY REGISTRAR <u>—</u> 24b. REGISTRAR'S SIGNATURE <u>—</u>	
ADDRESS <u>—</u>		DATE <u>AUG 7 '58</u>	

9VVVVVVVVVV

13. 51 8/1/22 25/10/12

The first: General knowledge and